Appendix 11
Sample Prior Authorization Spell of Illness Attachment

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT
(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Im	A	1234567890	55

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. Performing, OTR	87654321	(XXX) XXX -XXXX

(9) I. M. Referring
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. ☐ Physical Therapy SOI ☒ Occupational Therapy SOI ☐ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems.
Indicate the functional regression which has occurred and the potential to reachieve the previous skill level.
Recipient was involved in M.V.A. MM/DD/YY with resultant T.B.I with coma and other multiple internal injuries and orthopedic complications. Acute hospitalization and follow-up rehabilitation on MM/DD/YY. Recipient was discharged home on MM/DD/YY. Upon discharge to home, recipient was able to ambulate without assistance, perform all ADLs with minimal cueing from memory book and relied on memory book to perform cognitive tasks. Family completed housekeeping tasks. Nine months later, regression in the ability to perform self care was noted, and was admitted to a nursing home for the purpose of regaining functional abilities.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.
SeeAttached

D. What is the anticipated end date of the spell of illness?
MM/DD/YY

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. *I. M. Prescribing* — Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) — MM/DD/YY — Date

G. *I M Performing* — Signature of Therapist Providing Evaluation/Treatment — MM/DD/YY — Date